

ATTENTION:

Please do not complete this form. This form is only used to give you an idea of the questions we will ask when you apply. It will help you prepare for the interview.

APPLICATION FOR WIFE'S OR HUSBAND'S INSURANCE BENEFITS

(Do not write in this space)

I apply for all insurance benefits for which I am eligible under Title II (Federal Old-Age, Survivors, and Disability Insurance) and part A of Title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act, as presently amended.

☐ Supplement. If you have already completed an application entitled "APPLICATION FOR RETIREMENT INSURANCE BENEFITS", you need complete only the circled items. All other claimants must complete the entire form.

1.	(a) PRINT Name of Wage Earner or Self-Employed Person _____ (Herein referred to as the "Worker")	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(b) Enter Worker's Social Security Number _____	____ / ____ / ____	
2.	(a) PRINT your name _____	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(b) Enter your Social Security Number _____	____ / ____ / ____	
3.	Enter your name at birth if different from item 2. _____	FIRST NAME, MIDDLE INITIAL, LAST NAME	
4.	(a) Enter your date of birth _____	MONTH, DAY, YEAR	
	(b) Enter name of State or foreign country where you were born _____		
If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 5.			
	(c) Was a public record of your birth made before you were age 5? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	(d) Was a religious record of your birth made before you were age 5? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
5.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? _____	<input type="checkbox"/> Yes (If "Yes," answer (b) and (c).) <input type="checkbox"/> No (If "No," go on to item 6.)	
	(b) Enter name of person on whose Social Security record you filed other application. _____	FIRST NAME, MIDDLE INITIAL, LAST NAME	
	(c) Enter Social Security Number of person named in (b). (If unknown, write "Unknown") _____	____ / ____ / ____	
DO NOT ANSWER QUESTION 6 IF YOU ARE AGE 66 OR OLDER. GO ON TO QUESTION 7.			
6.	(a) Are you, or during the past 14 months have you been, unable to work because of illnesses, injuries or conditions? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(b) If "Yes," enter the date you became unable to work. _____	MONTH, DAY, YEAR	
If you are now AGE 62 or older, or you will be AGE 62 in this month or one of the next 4 months, answer item 7. If not, go on to item 8.			
7.	(a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968? _____	<input type="checkbox"/> Yes (If "Yes," answer (b).) <input type="checkbox"/> No (If "No," go on to item 8.)	
	(b) Enter dates of service _____	From: (Month, year)	To: (Month, year)
8.	Did you or the worker work in the railroad industry for 7 years or more? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

9.	(a) Do you have social security credits (for example, based on work or residence) under another country's social security system? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," answer (b).) (If "No," go on to item 10.)																																																						
	(b) If "Yes," list the country(ies). _____																																																							
10.	(a) Have you qualified for, or do you expect to qualify for a pension or annuity (or a lump sum in place of a pension or annuity) based on your own employment and earnings for the Federal government of the United States, or one of its States or local subdivisions? <i>(Social Security benefits are not government pensions.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes," check which of the items in item (b) applies to you.) (If "No," go on to item 11.)																																																						
	(b) <input type="checkbox"/> I receive a government pension or annuity. <input type="checkbox"/> I received a lump sum in place of a government pension or annuity. <input type="checkbox"/> I applied for and am awaiting a decision on my pension or lump sum.	<input type="checkbox"/> I have not applied for but I expect to begin receiving my pension or annuity: <div style="text-align: right;">_____ (Month, year)</div> (If the date is not known, enter "Unknown".)																																																						
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11. Enter below the information requested about each of your marriages. Include information on your marriage to the worker and any other marriages, whether before or after you married the worker.																																																								
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13. (a) How much were your total earnings last year? _____ \$

(b) Place an "X" in each block for each month of last year in which you did not earn more than *\$ _____ in wages, and did not perform substantial services in self-employment. These months are exempt months. If no months were exempt months, place an "X" in "NONE". If all months were exempt months, place an "X" in "ALL".

*Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

14. (a) How much do you expect your total earnings to be this year? _____ \$

(b) Place an "X" in each block for each month of this year in which you did not or will not earn more than *\$ _____ in wages, and did not or will not perform substantial services in self-employment. These months are exempt months. If no months are or will be exempt months, place an "X" in "NONE". If all months are or will be exempt months, place an "X" in "ALL".

*Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

15. Answer this item **ONLY** if you are now in the last 4 months of your taxable year (Sept., Oct., Nov., and Dec., if your taxable year is a calendar year).

(a) How much do you expect to earn next year? _____ \$

(b) Place an "X" in each block for each month of next year in which you do not expect to earn more than *\$ _____ in wages, and do not expect to perform substantial services in self-employment. These months will be exempt months. If no months are expected to be exempt months, place an "X" in "NONE". If all months are expected to be exempt months, place an "X" in "ALL".

*Enter the appropriate monthly limit after reading the instructions, "How Your Earnings Affect Your Benefits".

NONE		ALL	
Jan.	Feb.	Mar.	Apr.
May	Jun.	Jul.	Aug.
Sept.	Oct.	Nov.	Dec.

If you use a fiscal year, that is, a taxable year that does not end December 31 (with income tax return due April 15), enter here the month your fiscal year ends. _____ (Month)

If you are now under AGE 66 and do not have an entitled child in your care, answer item 16.

If you are AGE 66 or older or you have an entitled child in your care, go on to item 17.

PLEASE READ CAREFULLY THE INFORMATION ON THE OPPOSITE PAGE AND ANSWER ONE OF THE FOLLOWING ITEMS.
(See Page 5) _____

16. (a) I want benefits beginning with the earliest possible month that will be the most advantageous. _____ ☐

(b) I am age 65 (or will be age 65 within 4 months) and I want benefits beginning with the earliest possible month that will be the most advantageous, providing that there is no permanent reduction in my ongoing monthly benefit. _____ ☐

(c) I want benefits beginning with _____. I understand that either a higher initial payment or a higher continuing monthly benefit amount may be possible, but I choose not to take it. _____ ☐

MEDICARE INFORMATION

If this claim is approved and you are still entitled to benefits at age 65, you will automatically have hospital insurance protection under Medicare at age 65. If you are not also eligible for automatic enrollment in the Supplementary Medical Insurance Plan, this application may be used for voluntary enrollment.

COMPLETE THIS ITEM ONLY IF YOU ARE WITHIN 3 MONTHS OF AGE 65 OR OLDER

ENROLLMENT IN MEDICARE'S SUPPLEMENTARY MEDICAL INSURANCE PLAN: The medical insurance benefits plan pays for most of the costs of physicians' and surgeons' services, and related medical services which are not covered by the hospital insurance plan. Coverage under this SUPPLEMENTARY MEDICAL INSURANCE PLAN does not apply to most medical expenses incurred outside the United States. Your Social Security district office will be glad to explain the details of the plan and give you a leaflet which explains what services are covered and how payment is made under the plan.

Once you are enrolled in this plan, you will have to pay a monthly premium to cover part of the cost of your medical insurance protection. The Federal Government contributes an equal amount or more toward the cost of your insurance. Premiums will be deducted from any monthly Social Security, railroad retirement, or civil service benefit checks you receive. If you do not receive such benefits, you will be notified about when, where, and how to pay your premiums. If you are eligible for automatic enrollment, you will be automatically enrolled unless you indicate, by checking the "NO" block below that you do not want to be enrolled.

17. DO YOU WANT TO ENROLL IN THE SUPPLEMENTARY MEDICAL INSURANCE PLAN? ☐ Yes ☐ No

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS APPLICATION

I understand that SSA will use the earnings reported to SSA by my employer(s) and my self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. I also understand that it is my responsibility to ensure that the information I give SSA concerning my earnings is correct. I also understand that I must furnish additional information as needed when my benefit adjustment is not correct based on the earnings on my record.

BENEFITS MAY END if any of the following events occur. However, there are certain exceptions which are explained in the informational booklet which you will receive. You must report each of these events even if you believe an exception applies. We will advise you whether additional evidence is needed and how your benefits may be affected.

I AGREE TO PROMPTLY NOTIFY the Social Security Administration and to PROMPTLY RETURN ANY BENEFIT CHECK I receive if the check is for a month in or after the month in which:

- The worker DIES. (You may be entitled to survivor's benefits.)
- I am DIVORCED or my marriage is ANNULLED.
- I MARRY. (If I am entitled as a divorced spouse.)
- I NO LONGER HAVE IN MY CARE the worker's child or dependent grandchild under age 16 or disabled who is entitled to benefits.
- I am confined to jail, prison, penal institution or correctional facility for conviction of a crime or confined to a public institution by court order in connection with a crime.

REMARKS (You may use this space for any explanations. If you need more space, attach a separate sheet.)

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT

Date (Month, day, year)

Signature (First Name, Middle Initial, Last Name) (Write in ink)

Telephone number(s) at which you may be contacted during the day

SIGN
HERE

Area Code

FOR
OFFICIAL
USE ONLY

Direct Deposit Payment Address (Financial Institution)

Routing Transit Number

C/S

Depositor Account Number

☐ No Account

☐ Direct Deposit Refused

Applicant's Mailing Address (Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)

City and State

ZIP Code

County (if any) in which you now live

Witnesses are required ONLY if this application has been signed by mark (X), two witnesses who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in the Signature block.

1. Signature of Witness

2. Signature of Witness

Address (Number and Street, City, State and ZIP Code)

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**CHANGES TO BE REPORTED AND HOW TO REPORT
FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAYED, AND IN
POSSIBLE MONETARY PENALTIES**

- ▶ You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- ▶ You go outside the U.S.A. for 30 consecutive days or longer.
- ▶ Any beneficiary dies or becomes unable to handle benefits.
- ▶ Work Changes — On your application you told us you expect total earnings for _____ to be \$ _____.
Year

You ☐ (are) ☐ (are not) earning wages of more than \$_____ a month.

You ☐ (are) ☐ (are not) self-employed rendering substantial services in your trade or business.

(Report AT ONCE if this work pattern changes)

- ▶ Change of Marital Status — Marriage, divorce, annulment of marriage.
- ▶ You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.

- ▶ Custody Change or Disability Improves — Report if a person for whom you are filing, or who is in your care dies, leaves your care or custody, changes address, or, if disabled, the condition improves.
- ▶ You begin to receive a government pension or annuity (from the Federal government or any State or any political subdivision thereof) or present payment changes.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

WHEN A CHANGE OCCURS AFTER YOU RECEIVE A NOTICE OF AWARD, YOU SHOULD REPORT BY CALLING THE APPROPRIATE TELEPHONE NUMBER SHOWN NEAR THE TOP OF PAGE 6.

The law requires that a report of earnings be filed with SSA within 3 months and 15 days after the end of any taxable year in which you earn more than the annual exempt amount. You may contact SSA to file a report. Otherwise, SSA will use the earnings reported by your employer(s) and your self-employment tax return (if applicable) as the report of earnings required by law and adjust benefits under the earnings test. It is your responsibility to ensure that the information you give concerning your earnings is correct. You must furnish additional information as needed when your benefit adjustment is not correct based on the earnings on your record.

Under a special rule known as the Monthly Earnings Test, you can get a full benefit for any month in which you do not earn wages over the monthly limit and do not perform substantial services in self-employment regardless of how much you earn in the year. For retirement age beneficiaries this special rule can be used only for one taxable year which will usually be the year of retirement. For younger beneficiaries such as young wives and husbands (entitled only by reason of child-in-care), this special rule can be used for two taxable years. The first taxable year in which the monthly earnings test may be used is usually the first year they are entitled to benefits. The second taxable year in which the monthly earnings test can be used is always the year in which their entitlement to benefits stops. In all other years, the total amount of benefits payable will be based solely on your total yearly earnings without regard to monthly earnings or services rendered in self-employment.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE YOU ANSWER QUESTION 16.

Benefits may be payable for some months prior to the month in which you file this claim (but not for any month before the first month you will be age 62 for the entire month) if:

You will earn over the exempt amount this year. For the appropriate exempt amount, see "How Your Earnings Affect Your Benefits."

If your first month of entitlement is prior to age 65, your benefit rate will be reduced (but not for those months in which you have an entitled child under age 16 or disabled in your care). However, if you do not actually receive your full benefit amount for one or more months before age 65 because benefits are withheld due to your earnings, your benefit will be increased at age 65 to give credit for this withholding. Thus your benefit amount at age 65 will only be reduced if you receive one or more full benefit payments prior to the month you are age 65.

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY WIFE'S OR HUSBAND'S INSURANCE BENEFITS

TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOME- THING TO REPORT	BEFORE YOU RECEIVE A NOTICE OF AWARD	SSA OFFICE _____ DATE CLAIM RECEIVED _____
	AFTER YOU RECEIVE A NOTICE OF AWARD	

Your application for Social Security benefits has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you have a change of address,

or if there is some other change that may affect your claim, you—or someone for you—should report the change to the telephone number shown above. The changes to be reported are listed on page 5. Always give us your claim number when writing or telephoning about your claim.

If you have any questions about your claim, we will be glad to help you.

CLAIMANT	WORKER'S SURNAME IF DIFFERENT FROM CLAIMANT'S	SOCIAL SECURITY NUMBER

PAPERWORK REDUCTION ACT STATEMENT

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Collection and Use of Information From Your Application—Privacy Act/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended 42 U.S.C. 402(b), 402(c), 405(a), and 1395(ii). While it is voluntary, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage. Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another

governmental agency as follows:

1. to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
 2. to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and
 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security.)
- We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.